UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

AVASTIN (bevacizumab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Physician NPI_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Minimum age - 18 years old.
- Documentation of diagnosis of metastatic carcinoma of colon or rectum OR non-squamous, non-small cell lung cancer OR macular degeneration.

INFORMATION:

To be given in clinic setting only. Patients with HMO's (except IHC) will have to make arrangements with their HMO for coverage. Provider will bill with J code J9035, NDC number, and PA number.

AUTHORIZATION:

Initial prior is for 1 year

RE-AUTHORIZATION:

Subsequent PA is for 1 year, with an updated letter of medical necessity.